STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING _____ B. WING _____	C 03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	2222 MARGARET AVE TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for a Recertification and State Licensure Survey. This visit included the investigation of complaint numbers IN00162421, IN00164516, and IN00166386.

Complaint number IN00162421 Unsubstantiated due to lack of evidence.

Complaint number IN00164516 Substantiated. No deficiencies related to the allegations were cited.

Complaint number IN00166386 Substantiated. No deficiencies related to the allegations were cited.

Survey dates: February 26, 27, 2015 and March 2, 3, 4, 5, 2015

Facility number: 000564
Provider number: 155484
AIM number: 100285610

Survey Team:
Geoff Harris RN TC
Laura Brashear RN
Vickie Nearhoof RN
Mary Weyls RN March 2, 3, 4, 5, 2015

Census Bed Type:
SNF/NF: 112
NF: 1
Total: 113

Census Payor Type:
Medicare: 14
Medicaid: 85

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING _____ B. WING _____	C 03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	2222 MARGARET AVE TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Other: 14 Total: 113 Kindred Transitional Care And Rehab -Southwood was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Recertification and State Licensure Survey and the Investigation of Complaints IN00162421, IN00164516 and IN00166386. Quality Review 03/06/15 by Lisa McColly	F 000		